# ANALYST WORKSHEET
# HCSC

Carrier: _____
Contract Form Number: _____
Date(s) of Review: _____

Prior Contract:_____
Reel _____ Frame _____
Prior Effective Date: _____

## GENERAL REVIEW REQUIREMENTS
## Authority to Review Contract – RCW 48.44.070

| Topic | Subtopic | Reference | Specific Issue | Complies Y | Complies N | |
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| **Chemical Dependency** | *CPI Index* | WAC 284-53 T2000-04 | 1. $11,285 *(2003 CPI)* Minimum Limit In Any 24 Consecutive Months. This includes both treatment and supporting services. The minimum limit must be adjusted for inflation, using 1999 as a base year, each time contracts are filed. The consecutive 24 months begins with the contract start date, not first treatment date.<br>2. Benefit can not contain lifetime limit. | | | Contract Pg_____<br>Comments: |
| | *Detoxification Services* | RCW 48.43.093 WAC 284-53 | 1. Detox services are covered under the Emergency statute RCW 48.43.093. Detox costs do not count toward dollar limits, if not currently under chemical dependency treatment. Pre-notification for detox is not reasonable.<br>2. Pre-notification for non-detox services allowed if applied consistently as with other chronic illnesses. | | | Contract Pg_____<br>Comments: |
| | *Definitions* | RCW 48.44.245 | 1. Does the certificate define Chemical Dependency?<br>2. Definition must use chronic illness language.<br>3. Dependency based on substances controlled by 60.50RCW?<br>4. Changes “approved treatment facility” language to “approved treatment program” under RCW 70.96A.020. Detox treatment may be performed at any hospital licensed according to 70.41 RCW. | | | Contract Pg_____<br>Comments: |
| | *General Services* | RCW 48.44.240 WAC 284-53 | 1. Does the contract provide Chemical Dependency Benefits?<br>2. Extends coverage to all enrollees, not just the insured.<br>3. POS cost-sharing provisions may be incorporated. Restrictive contractual provisions not permitted if pertinent to chemical dependency treatment.<br>4. Carriers may impose no more than a 3-month pre-ex requirement, and if imposed, must be consistent with other chronic illness limitations.<br>5. Carriers may limit coverage to specific facilities, but must contain an adequate network per WAC 284-43-200 | | | Contract Pg_____<br>Comments: |

CFR – Code of the Federal Register
EEOC – U.S. Equal Employment Opportunity Commission
HIPAA - Health Insurance Portability and Accountability Act of 1996
PHSA – Public Health Service Act
RCW - Revised Code of Washington
TAA - Technical Assistance Advisories issued by OIC (example T2000-01)
WAC - Washington Administrative Code

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| **Compliance Requirements** | | WAC 284-43-125 | Has carrier complied with all Washington State and Federal Laws? | | | Contract Pg_____<br>Comments: |
| **Conscience Clause**<br><br>*Managed Care Mandate* | | RCW 48.43.065 | Does the contractual language allow for the free exercise of conscience or religion?<br>1. Has the Carrier filed their policy which complies with RCW<br>2. Any party to the contract may refuse to perform, cover, or receive specific services for reasons of conscience or religion | | | Contract Pg_____<br>Comments: |
| **Continuation of Care During Enrollee Absence** | *Federal Medical Leave Act* | FMLA | If the contract is being offered to Group of 50+ does it contain proper notification to the enrollee regarding medical coverage status during a period of leave under FMLA? | | | Contract Pg_____<br>Comments: |
| | *Labor Dispute* | RCW 48.44.250 | Does the brochure inform, and are the contract and brochure consistent with labor dispute continuation provisions?<br>1. Six month continuation period required for employee to directly pay premiums<br>2. Applies whether employer pays all or part of premium<br>3. All three actions – strike, lockout, other labor dispute – must appear in description of provision<br>4. After six months, employees must be given an opportunity to purchase a conversion contract | | | Contract Pg_____<br>Comments: |
| **Continuation Options Upon Termination** | *Consolidated Omnibus Budget Reconciliation Act* | COBRA | If the contract is being offered to Groups of 20+ does it contain continuation of coverage language in compliance with federal law? | | | Contract Pg_____<br>Comments: |
| | *Continuation of Coverage*<br><br>*Mandated Group Offering* | RCW 48.44.360 | A continuation option must be offered to the employer:<br>1. Offer to extend coverage for an agreed upon time period and rate paid to employer<br>2. Conversion and COBRA can run concurrently<br>3. After continuation is exhausted the person can purchase a conversion plan | | | Contract Pg_____<br>Comments: |
| | *Conversion Offered* | RCW 48.43.025<br>RCW 48.44.230<br>RCW 48.44.370<br>RCW 48.44.380<br>WAC 284-52 | 1. All contracts must provide notice of the right to convert to a conversion contract upon termination from the group contract.<br>2. Does the HCSC have on file and approved at least three conversion contracts with the OIC?<br>3. Does the conversion option provide continuous coverage, without a lapse?<br>4. Does the contract reflect that in the event an employee is denied a conversion contract due to misconduct, his or her spouse and dependents must be offered a conversion contract?<br>5. Does the conversion contract contain a pre-ex limitation, which imposes a limit beyond the original contract limit?<br>6. Does the conversion contract apply prior benefit charges against the lifetime conversion benefit?<br>a. The contract itself must contain a mini benefit, not an "enrollee" mini benefit.<br>7. Does the conversion contract provide that any deductible will be determined on a calendar year basis? | | | Contract Pg_____<br>Comments: |

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| | | | 8. Does the conversion contract provide for a 3-month deductible carryover?<br>9. Does the conversion contract allow for premium payment on a monthly basis?<br>10. Do the contract exclusions conform to the WAC<br>11. Does the contract contain medical or hospital exclusions not commonly used by the particular carrier in other group contracts?<br>12. Does the conversion contract provide that its benefits will be excess to any automobile, such as UIM, coverage?<br>13. Is there a notice on the face page of the contract, advising the subscriber that he/she may review and return the contract within 10 days of receipt, if not completely satisfied?<br>a. A 10% percent penalty shall be paid if monies are not refunded within 30 days | | | |
| | *Conversion Statement* | HCFA Ins Standards Bulletin 01-01 | If this is a **group** contract, does it contain a statement that says, If you accept conversion coverage at the end of coverage under this group health plan you will not qualify as a HIPAA eligible individual. | | | Contract Pg_____<br>Comments: |
| **Contract Examination and Standards** | *Examination/ Disapproval* | RCW 48.44.020 | Review for any inconsistent, ambiguous or misleading clauses, or exceptions and conditions, which unreasonably or deceptively affect the risk, purported to be assumed in the general coverage of the contract.<br>1. Must contain clear, definitive, WA state specific language for all:<br>a. terms, benefits, and conditions<br>b. Must avoid unreasonable restrictions on treatment or services<br>c. Must have a reasonable premium or benefit level assumed in relation to the benefits provided by the contract. | | | Contract Pg_____<br>Comments: |
| | *Exclusions, reduction and limitations* | WAC 284-43-820 | Does the contract or certificate of coverage contain a listing of exclusions, reductions, and limitations to covered benefits? | | | Contract Pg_____<br>Comments: |
| | *Rate Filing* | RCW 48.44.040 | Has the Carrier filed with the form submission corresponding rates for the contract including rate information for each rider? | | | Contract Pg_____<br>Comments: |
| | *Required Format* | WAC 284-44-030 | 1. The style, arrangement, and over-all appearance of the contract shall give no undue prominence to any portion of the text<br>a. The type must be of a general style<br>b. The point size shall be uniform, of acceptable point size<br>c. The "text" shall include all printed matter except those specific items stated<br>2. The exclusions, reductions, and limitations shall either be included with the benefit provisions, or under an appropriate caption<br>a. An exclusion, reduction, or limitation which applies to a particular benefit shall be Included with the applicable benefit provision.<br>3. A form number in the lower left-hand corner of the page shall identify each form including riders & endorsements.<br>4. The contract shall contain no provision purporting to make any portion of the HCSC charter, rules, bylaws, etc. a part of the contract that would limit its terms; unless attached to, or set forth in full in, the contract. | | | Contract Pg_____<br>Comments: |

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| | *Required Standards* | WAC 284-44-040 | 1. The contract cannot unreasonably limit benefits to a specified period of time.<br>2. A contract must provide that reasonable benefits will be restored upon each renewal of the contract or upon a calendar year basis<br>3. The contract cannot unreasonably restrict or delay the payment of benefits. Delays are not justified because the expenses incurred, or the services received, resulted from an act or omission of a third party. Delays are not justified because the expenses incurred, or the services received, resulted from an act or omission of a third party.<br>4. If the contract covers maternity, no waiting periods in advance of conception is allowed.<br>5. Is there a grace period of not less than 10 days following the due date for the payment of the subscriber's dues, fees or premium?<br>6. The contract may not contain any provision that gives the contractor, agent, employee, or designee the authority to make a decision relative to the contract or its coverage that is final and binding on the subscriber. A subscriber shall not be denied the right to have the controversy settled by legal or arbitration proceedings.<br>7. The contract may not require a "monthly treatment order."<br>8. If the contract restricts treatment to its network, a provision must be allowed for emergency treatment consistent with the scope of benefits provided by the contract. | | | Contract Pg_____<br>Comments: |
| **Coordination of Benefits** | *General* | RCW 48.21.200<br>WAC 284-51 | If the contract contains COB provisions, it shall be consistent with and no less favorable than the requirements of the WAC. | | | Contract Pg_____<br>Comments: |
| | *Allowable Expense* | WAC 284-51-050 | 1. Every group contract that provides for coordination of benefits to include the following definition:<br>a. "Allowable Expense" means (the usual, customary and reasonable) charge for any necessary health care service or supply when the service or supply is covered at least in part under any of the plans involved. When a plan provides benefits in the form of services or supplies rather than cash payments, the reasonable cash value of each service rendered or supply provided shall be considered an allowable expense.<br>2. When COB is restricted in its use to specific benefits in a contract, (for example, major medical benefits or dental benefits), the definition of "Allowable Expense" must include the corresponding services and supplies to which COB applies.<br>3. Adjudicative practices are not required to be included in the contract form, however, the contract form cannot include language that conflicts the requirements of the rule. | | | |
| | *Benefit Reduction* | WAC 284-51-185 | A group contract which provides for coordination of benefits shall contain a provision entitled "Effect on Benefits" stating the manner in which benefits are reduced by coordination | | | Contract Pg_____<br>Comments: |
| | *Disclosure of Coordination* | WAC 284-51-150 | Each certificate of coverage under a contract that provides for COB must contain at least in summary form, a description of the COB provision. | | | Contract Pg_____<br>Comments: |

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| | *Order of Benefit Determination* | WAC 284-51-075 | 1. The order of benefits for the plan(s) that cover a person as a dependent is clearly described.<br>2. When a claim under a plan with a coordination of benefits provision involves another plan which also has a coordination of benefits provision, the following rules will be applied by the insurers involved to decide the order in which the benefits payable under the respective plans will be determined. But in no event may the secondary carrier pay less (or provide "fewer benefits") than the amount specified in the COB statute and regulation.<br>a. The secondary carrier must pay for services that are covered under either the primary or secondary contract. This means that the secondary carrier will sometimes be required to pay for a service that is not covered or excluded under its own contract.<br>b. The benefits of a Plan that covers the person on whose expenses claim is based other than as a dependent are determined before the benefits of a Plan which covers such person as a dependent. | | | Contract Pg_____<br>Comments: |
| | *Plan Defined* | WAC 284-51-040 | 1. Health contracts that provide for coordination of benefits are required to contain a provision stating what benefits from the contract and other sources are to be recognized under the coordination provision.<br>2. Each such source shall be defined as a "Plan". | | | Contract Pg_____<br>Comments: |
| | *Required Provision for COB* | RCW 48.21.200<br>WAC 284-51-020 | 1. No health care plan providing hospital, medical or surgical expenses may reduce or refuse to pay such benefits otherwise payable there under solely on account of the existence of similar benefits.<br>2. A carrier may not administer COB in a way that reduces total benefits payable below an amount equal to 100% of total allowable expenses. | | | Contract Pg_____<br>Comments: |
| | *Right to Receive and Release Necessary Information* | WAC 284-51-140 | A Plan that provides for COB may contain:<br>1. For the purpose of determining and implementing this provision in any Plan, the insurer may, with such consent of the insured person, release to or obtain from any other insurer, organization or person any information, with respect to any person, which the insured considers necessary for such purpose.<br>2. Any person claiming benefits under this Plan shall furnish to the insured the information necessary for such purpose. | | | Contract Pg_____<br>Comments: |
| | *Time Limit* | WAC 284-51-100 | No insurer shall unreasonably delay payment of a claim by reason of the application of a COB provision. Any time limit in excess of 30 days is unreasonable. | | | Contract Pg_____<br>Comments: |
| **Cosmetic Surgery** | *Congenital Anomalies*<br><br>*Benefit Mandate* | RCW 48.44.212<br>WAC 284-52-070 | Does the contract provide coverage from the moment of birth for a child afflicted with a congenital disease or anomaly?<br>1. Contract shall include benefits for Reconstructive Surgery<br>2. Contract can't exclude benefits for incidents arising prior to plan coverage | | | Contract Pg_____<br>Comments |

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| | *Mastectomy (Reconstructive Surgery)*<br><br>*Benefit Mandate* | RCW 48.44.330<br>Women's Health & Cancer Rights Act of 1998 | Does the contract provide benefits for reconstruction following a Mastectomy:<br>1. Benefit restrictions such as "initial surgery" and "complications" can not be used to limit coverage for any stage of treatment<br>2. Surgery/reconstruction of the non-diseased breast to produce symmetrical appearance shall be included<br>3. Prostheses & physical complication including Lymphedemas shall be covered | | | Contract Pg_____<br>Comments |
| **Dependent Enrollment Requirements** | *21 Day Newborn Coverage*<br><br>*Managed Care Mandate* | RCW 48.43.115<br>ERIN Act | 1. Coverage for newborn must be no less mother's coverage for no less than three weeks, regardless of admission frequency<br>2. Written notification of the provisions is required to all certificate/policy holders | | | Contract Pg_____<br>Comments: |
| | *Disabled Child over Age Limit*<br><br>*Benefit Mandate* | RCW 48.44.200<br>RCW 48.44.210 | Does the contract continue coverage for a child beyond the limiting age when:<br>1. Child is incapable of employment and chiefly dependent for support<br>2. Proof is provided within 31 days of attaining limits and NO more frequently than annually after first 2 years of attainment | | | Contract Pg_____<br>Comments |
| | *Newborn & Adoptive Children Enrollment* | RCW 48.01.180<br>RCW 48.01.235<br>RCW 48.44.212<br>RCW 48.44.420<br>HIPAA | 1. Are the coverage requirements of newborn & adoptive children met?<br>a. Carriers cannot limit application period to 60 days unless additional premium is required<br>b. There shall be no waiting period for initial coverage or any service<br>c. Carriers cannot deny enrollment to newborn because other dependents not Enrolled<br>2. Does the contract meet the requirements with respect to eligibility and enrollment of children who are physically placed with the subscriber for the purposes of adoption and for whom the subscriber has assumed financial responsibility for medical expenses?<br>a. Coverage must be on same basis as other dependents<br>b. Coverage begins when subscriber assumes responsibility, not physical placement in the home<br>c. 60 notification period to carrier enforceable only when additional premium required<br>3. Carriers can not place unreasonable requirements on the child's parent to enroll them, including:<br>a. Requiring the child to be IRS dependent<br>b. Requiring proof of Paternity | | | Contract Pg_____<br>Comments: |
| | *Pre-Existing Condition* | PHSA 2701(d)(1)&(2)<br>45 CFR 148.120(f)(2) | Under **group** market rules, exclusions cannot be applied at all to a child who was covered by creditable coverage no later than 30 days after birth or after being adopted or placed for adoption. Note: State law requires 60 days. | | | Contract Pg_____<br>Comments: |

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| **Diabetes**<br><br>*Benefit Mandate* | | RCW 48.44.315 | Does the contract provide benefits for all subscriber diagnosed "Insulin using", "Non-insulin using", and "elevated blood glucose using" *(i.e. Pregnancy Induced):*<br>*If Contract does not provide Rx Benefits then:*<br>1. Self-management training & education when ordered by a M.D.<br>*If Contract provides Rx Benefits, then:*<br>1. Self-management training & education when ordered by a M.D. and;<br>2. Appropriate and medically necessary equipment and supplies | | | Contract Pg_____<br>Comments |
| | *DME* | RCW 48.44.315(2) | Does the carrier provide appropriate and medically necessary equipment and supplies,, which include:<br>1. Insulin Pumps and accessories to the pumps<br>2. Blood glucose monitors<br>3. Test strips for blood glucose monitors<br>4. Visual reading and urine test strips,<br>5. Insulin<br>6. Syringes<br>7. Insulin Infusion devices<br>8. Prescriptive oral agents for controlling blood sugar levels<br>9. Foot care appliances for prevention of complications associated with diabetes<br>10. Glucagon Emergency Kits | | | Contract Pg_____<br>Comments |
| **Disclosure Statements** | *Confidentiality* | RCW 48.43.505<br>WAC 284-43-820<br>P.L.102-106 sect. 501(b) & 505(b)(2) | Does the contract or certificate of coverage contain a statement of the carrier's policies for protecting the confidentiality of health information? | | | Contract Pg_____<br>Comments |
| | *Written Information* | RCW 48.43.510<br>WAC 284-43-820 | Does the contract or certificate of coverage contain a statement on how to request written information regarding any health care plan it offers? | | | Contract Pg_____<br>Comments: |
| **Emergency Treatment** | | RCW 48.43.005<br>RCW 48.43.093<br>WAC 284-43-130<br>WAC 284-44-040 | Does the contract comply with emergency treatment requirements?<br>1. Emergency out-of-network coverage must be consistent with scope of regular contract benefits<br>2. Emergency care definitions and provisions must be consistent with the law including incorporation of "prudent layperson" language<br>3. Carrier can not make sole determination of "Emergency " situations<br>4. Carrier shall not require prior authorization<br>5. Participating vs. Non-Participating cost sharing can be no greater than $50 differential | | | Contract Pg_____<br>Comments: |

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| **Every Category of Provider** | | RCW 48.43.045<br>RCW 48.43.005(4)<br>RCW 48.43.515<br>RCW 48.44.225<br>RCW 48.44.290<br>RCW 48.44.300<br>RCW 48.44.310<br>WAC 284-43-205<br>WAC 284-43-251<br>WAC 284-44-045 | Contracts must incorporate "every category of provider" language.<br>1. Every category of provider must be permitted, if treatment within the scope of licensure<br>2. Providers can be required to conform with carrier standards for cost-containment<br>3. Carriers may exclude specific treatments for stated conditions by specific provider types, if they show the treatment is not cost-effective or efficacious.<br>4. Reasonable limits may be placed on individual services, but not on provider type<br>5. Carrier can not impose composite annual dollar amount<br>6. Are the services of a Podiatrist and RN covered on the same basis as services of a MD?<br>7. Has the carrier offered chiropractic coverage on the same basis as other care?<br>8. Does the contract or certificate of coverage provide direct access to a participating chiropractor without the necessity of prior referral? Managed care cost and containment techniques may be utilized. | | | Contract Pg_____<br>Comments: |
| | *Denturist*<br>*If Dental covered* | RCW 48.44.500 | For contracts offering dental coverage, Denturist must be able to provide services within the scope of their license. | | | Contract Pg_____<br>Comments: |
| **General Anesthesia**<br><br>*Mandated Group Offering* | | RCW 48.43.185 | 1. Group Health Plans must offer medically necessary dental anesthesia coverage in a hospital or ambulatory surgery center if:<br>a. The patient is under age 7, developmentally delayed, or has other medical conditions & approved by patient's physician<br>2. Group Health plans that cover dental services and Group Dental Plans must cover medically necessary dental anesthesia performed in a dental office for children under age 7 and developmentally delayed person. | | | Contract Pg_____<br>Comments: |
| **Grievance Procedures** | *General* | RCW 48.43.055<br>RCW 48.43.530<br>WAC 284-43-615<br>WAC 284-44-040<br>WAC 284-43-620<br>WAC 284-43-630<br>29 CFR 2560<br>Godfrey v. Hartford Casualty | 1. Does the contract or certificate of coverage provide a clear explanation of the grievance and appeals process for the resolution of adverse determinations?<br>2. A contract must comply with mandated grievance procedure language, and cannot include a provision, which denies the subscriber the right to have a controversy determined by legal proceedings.<br>a. Aggrieved may proceed in process if fails to grant or reject request in 30 days<br>b. A carrier may not impose any costs on a claimant as a condition for filing or appealing a claim.<br>c. Carrier must adopt and implement a process for resolution of grievances and appeals of adverse determinations. The process shall consider NCQA standards as well as conform to the provisions of WAC 284-43. The carrier shall: | | | Contract Pg_____<br>Comments: |

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| | | | i) Provide an explanation of the process upon request, enrollment and annually to covered persons and subcontractors<br>ii) Register and respond to written and oral complaints and appeals<br>iii) Send notification acknowledging receipt of complaints and appeals<br>iv) Consider all information submitted<br>v) Investigate and resolve all complaints and appeals<br>vi) Develop and maintain a tracking mechanism<br>vii) Not require an enrollee file a compliant prior to seeking an appeal of a decision<br>3. Handle all requests to reconsider as an appeal if it was a resolution of a complaint made by an enrollee | | | |
| | *Adverse Determination and IRO* | RCW 48.43.055<br>WAC 284-44-040<br>WAC 284-43-620<br>WAC 284-43-630 | Appeal of Adverse Determination<br>1) An enrollee or their representative may appeal an adverse determination. The carrier must:<br>a) Reconsider the adverse determination and notify the covered person of its decision within 14 days of receipt, unless notification go the covered person that an extension is necessary, but cannot delay decision beyond 30 days of request without the informed, written consent of the covered person<br>b) If delay would jeopardize the covered person's life or health, the carrier shall expedite the process either a written or an oral appeal and issue a decision within 72 hours of receipt<br>c) Appeals shall be evaluated by health care providers who were not involved in the initial decision and who have expertise in the field encompassing the condition or disease<br>d) Carrier shall issue notification of the adverse determination including the reasons, and instructions of obtaining an appeal<br><br>Independent Review Organization<br>1. A covered person may seek review by an IRO after exhausting the carrier's grievance process and receiving an unfavorable decision, or after the carrier has exceeded the timelines. A carrier may establish a process to bypass the grievance and allow the direct appeal to an IRO<br>2. A carrier must provide information to the IRO within 3 business days<br>3. When an enrollee requests and independent review the carrier must continue to provide the health service if requested by the enrollee until a determination is made under this section. If the determination affirms the carrier's decision, the enrollee may be responsible for the cost of the continued health service.<br>4. A carrier must implement the IRO determination promptly and pay the IRO's charges. | | | Contract Pg_____<br>Comments: |

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| | *Definitions* | RCW 48.43.530<br>WAC 284-43-130 | "**Grievance**" is a written or an oral complaint submitted by or on behalf of a covered person regarding: (a) Denial of health care services or payment for health care services (b) Issues other than health care services or payment for health care services including dissatisfaction with health care services, delays in obtaining health care services, conflicts with carrier staff or providers; and dissatisfaction with carrier practices or actions unrelated to health care services.<br><br>"**Adverse determination and non-certification**" is a decision by a health carrier to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits including the admission to or continued stay in a facility. | | | Contract Pg_____<br>Comments: |
| | *Experimental and Investigative* | WAC 284-44-043<br>WAC 284-43-620 | If the contract includes exclusion, reduction or limitation for services that are experimental or investigative, are all requirements met?<br>1. The definitions of E&I treatment must be included in the CofC<br>2. A denial due to E&I must be done in writing within 20 working days of receipt of a fully documented request. Extension of the review period beyond this period may only be done with the informed written consent of the individual<br>3. Whenever an adverse determination would jeopardize the covered person's life or materially jeopardize the covered person's health, the carrier shall expedite and process whether a written or an oral appeal and issue a decision no later than 72 hours after receipt of the appeal. | | | Contract Pg_____<br>Comments: |
| | *Review and Appeal of Adverse Determination* | RCW 48.43.530(5)<br>WAC 284-43-620 | Does the contract or certificate of coverage describe an expedited process requiring a decision no later than 72 hours after receipt of an appeal when an adverse decision would jeopardize a person's life or health including the ability to regain maximum function? | | | Contract Pg_____<br>Comments: |
| | *Independent review of adverse determination* | RCW 48.43.535<br>WAC 284-43-630 | Does the contract or certificate of coverage explain that a subscriber may seek a review by an independent review organization of an adverse decision after exhausting the carrier's grievance process and receiving a decision that is unfavorable to the covered person, or after the carrier has exceeded the timelines for grievance provided in WAC 284-43? | | | Contract Pg_____<br>Comments: |
| **Group Certificates** | | WAC 284-44-030<br>WAC 284-44-050<br>WAC 284-49-100<br>*Fittro v. Lincoln Natl* | Group certificates must be furnished to each member of a group under a health contract.<br>1. The style, arrangement, and appearance of the contract shall give no undue prominence to any portion of the contract text<br>2. Language must be clearly understandable, and lay out the essential features of the coverage.<br>3. The certificate may be in booklet or brochure form.<br>4. Certificates must be filed with the OIC.<br>5. Any amendment shall necessitate prompt re-issuance of the certificate.<br>6. If there is a conflict in language between the contract and CofC the certificate governs. | | | Contract Pg_____<br>Comments: |

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| **Group Enrollment Requirements** | *Genetic Exclusion* | PHSA 2701(b)(1)(B) | Under **group** market rules an exclusion cannot be applied because there is genetic information suggesting a particular condition. This contract may not contain a pre-existing exclusion for genetic information. | | | Contract Pg_____ Comments: |
| | *Non-confinement Clause* | HCFA Ins Standards Bulletin 00-01 | A carrier may not use any health condition to delay the enrollment of an "eligible individual" or eligible persons under group market rules who is otherwise eligible for coverage. Policies may not delay coverage for persons who are confined to a hospital. | | | Contract Pg_____ Comments: |
| | *Portability* | RCW 48.43.015 | All medical contracts must conform to all portability standards.<br>1. Large groups (51+) have a three months pre-existing waiting period. Creditable coverage must meet HIPAA definition for the first 63 day period, from 64 to 90 days "similar" coverage is defined by state law.<br>2. Small Groups (50-) have a nine months pre-existing waiting period. Creditable coverage must meet HIPAA definition for the first 63 day period, from 64 to 90 days "similar" coverage is defined by state law | | | Contract Pg_____ Comments: |
| | *Pre-existing Condition* | RCW 48.43.025<br>RCW 48.43.012 | All medical contracts must conform to all pre-ex standards.<br>1. Large groups (51+) have a maximum waiting period of 3 months.<br>2. Small groups (50-) and individual plans have a maximum waiting period of 9 months.<br>3. Group plans must conform to the HIPAA definition of Pre-existing condition (Medical advice, diagnosis, care or treatment recommended or received during 6-month look back) Individual plans may require additional language of for which a prudent layperson would have sought advice or treatment. "Eligible individuals" under HIPAA have no pre-ex.<br>4. A carrier may not develop a separate rate classification based upon pre-ex conditions. | | | Contract Pg_____ Comments: |
| | *Pre-existing Exclusion* | PHSA 2701(a) | Does this contract limit all pre-existing conditions to 12 months or less. A contract may not contain language that extends pre-existing condition exclusions to a period exceeding 12 months. | | | Contract Pg_____ Comments: |
| | *Special Enrollment Periods* | PHSA 2701(f) | For **group** contracts, does the certificate of coverage explain what events trigger a special enrollment period? A special enrollment period can occur if a person with other health coverage loses that coverage or if a person becomes a new dependent through marriage, birth, adoption or placement for adoption. If a triggering event is a birth, adoption or placement for adoption, the child, the employee, and the employee's spouse are entitled to special enrollment, either individually or in any combination. | | | Contract Pg_____ Comments: |
| **Group Master Application** | *Certificate of Creditable Coverage* | PHSA 2701(e)<br>45 CFR 148.124 | Does the application include information of what a certificate of creditable coverage is and what other documentation that you may use to show prior creditable coverage? These include the following:<br>1. Pay stubs that reflect a premium deduction;<br>2. Explanation of benefit forms;<br>3. A benefit termination notice from Medicare or Medicaid; and<br>4. Verification by a doctor or your former health care benefits provider that you had prior health coverage. | | | Contract Pg_____ Comments: |

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| | *Creditable Coverage* | PHSA 2701(c)<br>45 CFR 146.113 | Does the application include a description of types of creditable coverage:<br>1. A group health plan (includes Cobra)<br>2. Health insurance coverage (includes individual coverage, college or school insurance, short-term limited duration insurance)<br>3. Medicare Part A or Part B<br>4. Medicaid,<br>5. Indian Health Service or tribal organization medical program<br>6. A State health benefits risk pool<br>7. TRICARE (military health care program for dependents & retirees)<br>8. Federal Employees Health Benefit Plan<br>9. A public health plan<br>10. A health plan under the Peace Corps Act | | | Contract Pg_____<br>Comments: |
| | *Mandatory Offerings* | | Does application offer to groups the following benefits for purchase:<br>1. TMJ services of at least one option containing $1000/$5000 limitation<br>2. Mental Health Services | | | Contract Pg_____<br>Comments: |
| **Guaranteed Renewability** | | RCW 48.43.035<br>WAC 284-43-720<br>WAC 284-43-730 | All medical contracts must conform to Guaranteed Issue & Continuity of Coverage requirements<br>1. Carrier may not terminate enrollee due to failure of Provider-Patient ability to establish care relationship.<br>2. Enrollee may not be terminated for reasons other than those stipulated by law without benefit of Grievance Procedure protections. | | | Contract Pg_____<br>Comments: |
| **Home & Hospice Coverage**<br><br>*Mandated Group Offering* | *Alternative to Inpatient Care*<br><br>*Benefit Mandate* | WAC 284-44-500 | Does the contract:<br>1. Allow home health care in lieu of hospitalization with consent of enrollee<br>2. Provide care in the most appropriate and cost-effective setting | | | Contract Pg_____<br>Comments |
| | *DME* | RCW 70.126.020 | 1. Does the contract include those services and supplies required by a Home Health Agency/Hospice?<br>2. Carrier may not impose additional cost restrictions which require enrollee to pay for equipment or rental of equipment. | | | Contract Pg_____<br>Comments |
| | *Home Health* | RCW 48.44.320 | 1. Minimum of 130 visits for home healthcare, not to include non-care based visits<br>2. May require written treatment plan approved by physician | | | Contract Pg_____<br>Comments: |
| | *Hospice Care* | RCW 48.44.320 | Minimum of six months with an option for an additional six months | | | Contract Pg_____<br>Comments: |
| **Mammogram**<br><br>*Mandated Benefit* | | RCW 48.44.325<br>WAC 284-44-046 | Does the contract provide benefits for screening and diagnostic mammography services when referred by a member's M.D., ARNP, or Physicians Assistant? | | | Contract Pg_____<br>Comments |
| **Maternity Benefits** | *Congenital Anomalies (Prenatal Testing)*<br><br>*Mandated Group Offering* | RCW 48.44.344<br>WAC 246-680-020 | The plan must cover prenatal testing for congenital disorders if it covers maternity<br>1. Carrier must determine medical necessity using the standards as set forth by the Board of Health<br>2. Carrier may determine medical necessity on case by case basis if partner is carrier of genetic disease.<br>3. Carrier may not impose restrictions which limit review for services to medical director determination only | | | Contract Pg_____<br>Comments |

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| | *Direct Access to Services* | WAC 284-43-250 | Does the contract impose notification or prior authorization for receiving women's health care services unfairly:<br>1. Carrier may not impose a limitation on maternity services that would require all child birth to occur in a hospital<br>2. Carrier may not impose requirement which requires a physician to conduct a delivery<br>3. Carrier must cover medically necessary supplies of a home birth | | | Contract Pg_____<br>Comments |
| | *Length of Stay*<br><br>*Managed Care Mandate* | RCW 48.43.115<br>ERIN Act<br>PSHA 2704 | Does the contract allow the health care provider ***in consultation*** with the mother to make decisions regarding care and length of stay in a hospital?<br>1. If length of stay guideline is stated must be no less than: 48-hour normal birth/96 caesarian section birth.<br>2. The contract can not restrict follow-up care when ordered by the attending provider ***in consultation*** with the mother<br>3. The Carrier must provide notice to policyholders regarding this coverage yearly by January 1st. | | | Contract Pg_____<br>Comments |
| | *Pregnancy* | RCW 48.43.025<br>PHSA 2701(d)(3) | For **group** contracts there can be no pre-existing condition exclusion for pregnancy, no matter when pregnancy began and whether medical advice, diagnosis, care or treatment was recommended or received for the pregnancy. This contract may not contain a pre-existing exclusion for pregnancy even if the previous health plan did not cover pregnancy. | | | Contract Pg_____<br>Comments |
| | *Pregnancy Discrimination* | Title VII of the Civil Rights Act<br>EEOC Compliance Manual | A plan may not unreasonably discriminate against pregnant women. *Unreasonable discrimination includes:*<br>1. Restricting travel during pregnancy including the 3rd trimester.<br>2. Charging higher premium for care | | | Contract Pg_____<br>Comments |
| | *Unfair Practices* | RCW 49.60.040(3)<br>WAC 162-30-020 | If the group contract is being sold to an employer who directly or indirectly employs either eight or more persons, does it include full health insurance coverage, including benefits for pregnancy and childbirth? | | | Contract Pg_____<br>Comments |
| **Mental Health Coverage** | | RCW 48.43.087<br>RCW 48.43.091<br>RCW 48.44.340<br>WAC 284-43-810 | If the carrier offers mental health coverage it must provide:<br>1. Any one of four specified provider types may render treatment.<br>2. Treatment must be covered under U&C rates. Each provider type may have a separate U&C rate established.<br>3. A CMHA must have in place a plan for quality assurance and peer review, and be supervised by a physician<br>4. Carrier must comply with reporting requirements<br>5. Must be offered on an all-or-nothing basis<br>6. The carrier can not prohibit the subscriber from contracting outside of the plan<br>7. The contract must contain the statement of "Mental Health Services & Your Rights"<br>8. Complies with guidelines for use of a perform utilization review<br>9. A Carrier must waive any mental health pre-authorization requirement for enrollees who are involuntarily committed to and subsequently treated in a state hospital | | | Contract Pg_____<br>Comments |

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| *Mandated Group Offering* | *Mental Health Parity* | 62 Fed Reg 66957<br>Dec 22, 1997 | For large groups (51+) a carrier may not impose an aggregate lifetime or annual limit on mental health benefits if it does not include an aggregate lifetime or annual limit on any medical/surgical benefits or apply to less than one-third of all medical/surgical benefits.<br><br>MHPA does **not** prohibit group health plans from:<br>1. Increasing co-pays or limiting the number of visits for mental health benefits<br>2. Imposing limits on the number of covered visits, even if the plan does not impose similar visit limits for medical and surgical benefits; and<br>3. Having a different cost-sharing arrangement, such as higher coinsurance payments, for mental health benefits as compared to medical and surgical benefits. | | | Contract Pg_____<br>Comments |
| **Neurodevelopment Therapy** | | RCW 48.44.450 | Does the contract provide benefits for neurodevelopment therapies?<br>1. Must provide benefits for children up to and including age six<br>2. Services covered must include physical, speech, and occupational therapies.<br>3. Benefits shall be provided to restore and improve function, and to prevent deterioration.<br>4. Benefits may be subject to annual or lifetime benefit limits.<br>5. NOTE: Testing for therapy is implied. | | | Contract Pg_____<br>Comments: |
| **Pharmacy** | *Contraceptive Care*<br><br>*Benefit Mandate* | WAC 284-43-822<br>AGO 2002No.5 | 1. It is unfair practice for any carrier to restrict, exclude, or reduce coverage on the basis of sex<br>2. Health plans which include Rx benefits shall not exclude coverage of prescription drugs and devices including associated medical services for prescribing, dispensing, delivery, distribution, administration and removal of contraceptive devices<br>3. Benefit waiting period may not be more restrictive than those required of other Rx benefits<br>4. Carrier may limit to closed formulary but it shall cover each required type<br>5. If excludes coverage for nonprescription drugs/devices it may also exclude for nonprescription drugs/devices<br>6. FDA approved Prescription Contraceptives shall include: Contraceptive Drugs, Barrier methods, and Emergency Contraception | | | Contract Pg_____<br>Comments: |
| | *Disclosure (if offered)* | RCW 48.44.465<br>WAC 284-30-450 | 1. Contracts that offer prescription drug coverage must:<br>a. Upon request of (prospective) enrollee furnish information regarding drug formulary requirements<br>b. A carrier cannot exclude a drug solely because of lack of FDA approval for the given use<br>2. An HCSC may not retract an issued authorization on a pharmacy claim. | | | Contract Pg_____<br>Comments: |
| | *Off Label Use of Drugs* | WAC 284-30-450 | All policies and contracts providing pharmacy coverage must provide coverage for FDA approved drugs that have many other beneficial uses as confirmed by other research studies, reference, compendium, or the Federal Government. | | | Contract Pg_____<br>Comments: |

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| | *Pharmacy Services Statement of Right* | WAC 284-43-815 | Does the contract or certificate of coverage contain the "Your right to Safe and Effective Pharmacy Services" statement? | | | Contract Pg_____<br>Comments: |
| | *Prescription Drug Formulary* | RCW 48.43.510<br>WAC 284-43-820 | Does the contract or certificate of coverage contain an offer to provide a listing of covered benefits including prescription drugs, including a formulary and how a subscriber may be involved in decisions about benefits? | | | Contract Pg_____<br>Comments: |
| | *Terms* | WAC 284-43-820 | Does the contract or certificate of coverage contain definitions of terms including formulary, generic versus brand name, medical necessity or other coverage criteria including policies regarding drug coverage? | | | Contract Pg_____<br>Comments: |
| **Provider Requirements** | *Continuation of Care Upon Provider Termination* | RCW 48.43.515(7)<br>WAC 284-43-251 | Does the carrier allow an enrollee whose PCP contract is being terminated from the plan to continue care under the terms of the contract for at least sixty (60) days following notice of termination to the enrollee? | | | Contract Pg_____<br>Comments: |
| | *Access to Providers*<br><br>*(Managed Care Plans Only)* | RCW 48.43.515<br>WAC 284-43-251 | Does the contract or certificate of coverage permit changing primary care providers at any time, becoming effective no later than the beginning of the month following the request? | | | Contract Pg_____<br>Comments: |
| | *Participating Provider Definition (when provided)* | RCW 48.44.010<br>WAC 284-43-320(2)(d) | 1. The definition of "participating provider" must be consistent with the statutory and regulatory definitions.<br>2. Definition can not contain language that conflicts with Provider Agreement requirements, including:<br>a. Provider may not bill enrollee for covered services except for deductible, co-payments, or coinsurance. | | | Contract Pg_____<br>Comments: |
| | *Payment for Non-par Services* | RCW 48.44.026<br>T 2000-1 | A health care service contract is not required to state to whom benefits will be paid. However, if it does include such a provision, that provision may not conflict with RCW 48.44.026 | | | Contract Pg_____<br>Comments: |
| | *Second Opinion* | RCW 48.43.515(6)<br>WAC 284-43-251 | Does the contract or certificate of coverage explain how to obtain a second opinion consultation?<br>1. Enrollee may seek a second opinion regarding any medical diagnosis or treatment plan<br>2. Enrollee will be able to choose from a list of qualified participating providers. | | | Contract Pg_____<br>Comments |
| | *Specialist Standing Referral*<br><br>*(Managed Care Plans Only)* | RCW 48.43.515<br>WAC 284-43-251 | Does the contract or certificate of coverage explain that you may request a standing referral for specialist services if you have a complex or chronic medical condition? | | | Contract Pg_____<br>Comments: |
| **PKU**<br><br>*Mandated Benefit* | | RCW 48.44.440<br>WAC 284-44-450 | Does the contract provide the formulas necessary for the treatment of PKU?<br>1. Exempt form pre-existing condition limitations<br>2. Dollar limits can not be more restrictive than those required of other disorders | | | Contract Pg_____<br>Comments: |

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| **Retrospective Denial** | | RCW 48.43.525 | Carrier shall not retrospectively deny coverage for emergency and nonemergency care that had prior authorization under the plan's written policies at the time the care was rendered. | | | Contract Pg_____<br>Comments: |
| **Service Outside the Plan Allowed**<br><br>*Managed Care Mandate* | | RCW 48.43.085 | Does the contractual language allow for the enrollee to access services outside of the health plan? | | | Contract Pg_____<br>Comments: |
| **Standard of Care** | | RCW 48.43.545 | 1. Does contract contain wording regarding standard of care?<br>2. A health carrier shall adhere to the accepted standard of care and is liable for any and all harm caused by its failure to follow the standard of care.<br>3. Carrier is liable for damages if it causes harm to enrollees.<br>4. Liability cannot be transferred from the Carrier to another entity.<br>5. Any action arising under this provision shall not be limited to less than three years of the completion of the IRO | | | Contract Pg_____<br>Comments: |
| **Subrogation** | | WAC 284-44-040<br>OIC Bulletin 79-4<br>Great-West Life & Annuity Ins v. Knudson<br>Thiringer v. American Motors Ins. | If the contract includes a subrogation provision, does it:<br>1. Stipulate the Carrier is entitled only to excess after subscriber fully compensated<br>2. Inform the subscriber that Legal expenses can be apportioned equitably, whether or not recovery made<br>3. Have any provision which would inappropriately require full reimbursement for all medical expenses.<br>4. The contract cannot unreasonably restrict or delay the payment of benefits. Delays are not justified because the expenses incurred, or the services received, resulted from an act or omission of a third party. | | | Contract Pg_____<br>Comments: |
| **Timely Filing** | *Standard Master Contract* | WAC 284-43-920 | Be filed before being offered for sale to the public and within 30 days after the end of the 18 month approval period | | | Contract Pg_____<br>Comments: |
| | *Negotiated Groups* | WAC 284-43-920 | Be filed within 30 working days of:<br>a) Completion of Group Negotiation<br>b) Premium Renewal Date | | | Contract Pg_____<br>Comments: |
| **TMJ**<br><br>*Mandated Group Offering* | | RCW 48.44.460<br>WAC 284-44-042 | 1. Does Group Application contain mandatory offering?<br>2. If group accepts benefit: They must be offered$1000 calendar yr. /$5000 lifetime after deductibles, Co-pays, etc<br>a. If group declines 1000/5000 may then negotiate benefit either up or down<br>3. Consider the scope of services, coinsurance , and pre-ex must be same as other common conditions<br>4. Must be offered on Dental Only Coverage | | | Contract Pg_____<br>Comments |
| **Unfair and Discriminatory Practices** | | RCW 48.44.110<br>RCW 48.44.120<br>RCW 48.44.140<br>RCW 48.44.220<br>HIPAA | 1. A carrier cannot deny coverage to any person on account of a sensory, mental, or physical handicap.<br>2. No person shall make, publish, or disseminate any false, deceptive, or misleading representation or advertising on behalf of a HCSC. Nor shall the terms of a contract be misrepresented. | | | Contract Pg_____<br>Comments |
| | *Non-discrimination Clause* | 45 CFR 146 | Is the carrier's exclusion for specific disease, limitation or exclusion for a specific benefit, treatment or drugs applied uniformly to all similarly situated individuals, and not directed at individual participants or beneficiaries based on a health factor? | | | Contract Pg_____<br>Comments: |

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| **Women's Direct Access** | | RCW 48.42.100<br>WAC 284-43-250<br>T 99-4 | Women's health care language must allow for direct access, to all women's HC providers, for women's services.<br>1. MD, OD, ARNP and Midwife, provider-types shall be in the network and accessible to subscribers<br>2. May not require PCP prior referral<br>3. Can not impose discriminatory Cost sharing provisions<br>4. Subscriber shall be notified upon enrollment and yearly thereafter regarding direct access provision | | | Contract Pg_____<br>Comments: |

## SPECIFIC INDIVIDUAL MANDATES

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| **10 Day Free Look** | | RCW 48.44.230 | Does the contract provide a review period of no less than 10 days in which an individual may return the policy if not completely satisfied?<br>1. Notice may be provided on either the face sheet or by attachment<br>2. 10% penalty shall be paid if refund is not within 30 days | | | Contract Pg._____<br>Comments: |
| **Application** | *Federal definition of "eligible individual"* | PHSA 2741(b)<br>45 CFR 148.103 | Does the application include the following federal definition of an "eligible individual" for the purposes of excluding pre-existing conditions and giving credit for creditable coverage?<br>1. You have at least 18 months of creditable coverage without a significant break in coverage – a period of 63 or more days during all of which you had no coverage, and<br>2. Your most recent cov must have been a group health plan and<br>3. You are not eligible for coverage under any other group health plan and<br>4. You are not eligible for Medicare or Medicaid and<br>5. You do not have other health insurance<br>6. You did not lose cov for not paying the premiums or for fraud, and<br>7. You accepted and used up your COBRA continuation coverage. | | | Contract Pg._____<br>Comments: |
| **Cancellation Notice** | | RCW 48.44.260 | A carrier must, upon written request, give a written explanation of their denial, non-renewal, or cancellation of coverage.<br>1. The explanation must set forth in simple language understandable to a person of average intelligence, education, reading ability | | | Contract Pg._____<br>Comments: |
| **Dependent Continuation in Case of Death** | | RCW 48.44.400 | All contracts must contain a continuance provision for spouse and dependent coverage in the event of death or divorce of enrollee.<br>1. Coverage must continue under the same contract form, not under a conversion or other policy<br>2. No physical exam statement of health or other proof of insurability may be required | | | Contract Pg._____<br>Comments: |
| **Enrollment Requirements** | *Portability* | RCW 48.43.015 | Individual plans have a nine months pre-existing waiting period. The federal definition for eligible individual must be applied. Credit must be given for a prior group health benefits plan or individual health benefit plan, other than a catastrophic health and:<br>(a) the benefits under the previous plan provide equivalent or greater overall benefit coverage than that provided in the health benefit plan the individual seeks to purchase<br>(b) the person is seeking an individual health benefit plan due to his or her change of residence from one geographic area in Washington state where his or her current health plan is not offered if application for coverage is made within 90 days of relocation or<br>The health care provider with whom he or she has an established care relationship and from whom he or she has received treatment within the past 12 month is no longer part of the carrier's provider network under his or her existing Washington individual health benefit plan, is part or another carriers next work and application is made within 90 days of the provider leaving the network. | | | Contract Pg._____<br>Comments: |

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| | *Pre-existing Condition* | RCW 48.43.012 | Individual plans pre-ex shall not apply to prenatal care services<br>Costs associated with delivery services are not considered to be part of prenatal/post care and may be excluded under this provision | | | Contract Pg._____<br>Comments: |
| **Guaranteed Renewability** | | RCW 48.43.038<br>WAC 284-43-720<br>WAC 284-43-730 | All individual health plans must conform to Guaranteed Issue & Continuity of Coverage requirements<br>1. Carrier may not terminate enrollee due to failure of Provider-Patient ability to establish care relationship.<br>2. Enrollee may not be terminated for reasons other than those stipulated by law without benefit of Grievance Procedure protections. | | | Contract Pg._____<br>Comments: |
| **Pregnancy** | | RCW 48.43.012 | Individual health plans may not require a pre-existing condition exclusion for pregnancy if the person is an "eligible individual" under the federal definition. Under state law pre-existing condition shall not apply to **prenatal** care services. | | | Contract Pg_____<br>Comments: |
| **Prescription Drug** | | RCW 48.43.041 | All plans other than catastrophic shall include Rx benefits with at least a two thousand dollar benefit payable annually. | | | Contract Pg._____<br>Comments: |
| **Standard Health Questionnaire** | | RCW 48.43.018<br>Washington State Health Insurance Pool (WSHIP) | Does the application clearly state the exceptions for individual who are not required to fill out the Standard Health Questionnaire? The exception are:<br>1. You have moved from one part of Washington State to another part of Washington State where your health plan is not offered.<br>2. Your doctor cannot treat you because they have stopped being a part of your Insurance Carrier's provider network for your individual health plan or;<br>3. You are applying for medical insurance because you have used up all the time on your Cobra. Note: Application should allow for applying for coverage within 90 days of expiration of existing Cobra.<br>Note: newborns or a newly adopted child enrolled within 60 days of birth or adoption cannot be Health Screened. | | | Contract Pg_____<br>Comments: |